0667 Children's Autism Waiver Definitions

Effective 1/1/2012

1. Children's Autism Training

Children's Autism Training (CAT) is a direct training service designed to assist the child in acquiring, retaining and generalizing the self-help, socialization, cognitive, communication, organizational skills and the positive behaviors necessary to function successfully in home and community settings. The staff person will provide hands on training using evidence based Applied Behavior Analysis practices and methods. Training goals will be outcome based and progress toward goals will be evidenced by training data. Children's Autism Training seeks to develop skills in the following areas, including, but not limited to:

1. Social skills, and related skills to enhance participation across all environments (school, home and community settings) and relationships, including but not limited to imitation, initiation of social interactions with adults and peers, reciprocal exchanges, parallel and interactive play with peers and siblings;
2. A functional communication system which may include expressive verbal language, receptive language and nonverbal communication skills and augmentative communication;
3. Increased engagement and flexibility in the exhibition of developmentally appropriate behaviors, including, but not limited to, play behavior, attending behavior, responding to environmental cues (including cues from the training staff and others) and cooperation with instructions;
4. Replacement of inappropriate behaviors with more conventional and functional behaviors;
5. Working with caregivers and others in the environment to promote the child's competence and positive behavior;
6. Fine and gross motor skills used for age appropriate functional activities, as needed;
7. Cognitive skills relating to play activity and academic skills;
8. Adaptive behavior and self-care skills to enable the child to be more independent, and/or;

9. Independent exhibition of organizational skills including, but not limited to, initiating and completing a task independently, asking for help, giving instructions to peers and following instructions from peers, following routines, self-monitoring and sequencing behavior.

The training effort will occur where the child lives, attends childcare and/or socializes with peers.

The bulk of training is likely to occur in the child's home. Training may be delivered in group settings with same age peers or in one to one settings, based on the assessed needs of the child. The majority of training will be delivered in one to one settings.

The plan of care, based upon the results of a formal assessment and identification of needs, provides the general goals and specific objectives toward which training efforts are directed. The plan of care also specifies the appropriate settings in which services will be provided.

Supervision and support is provided by the trainer as necessary for the care of the individual. Each training objective is specified in the plan of care and is clearly related to the individual's long term goal. The staff person providing CAT services will be trained by the staff person providing Program Design and Monitoring (PDM) services and will follow the specific written training protocols developed by PDM staff in working with and training the child.
Services may not be provided to children who are inpatients or residents of a nursing home, hospital or other institutional setting.

Children's Autism Training does not duplicate any other service available to the client, including those services under IDDEA or the Montana Medicaid State Plan. The training will not duplicate activities or resources provided by other sources but will be integrated across environments to promote the generalization of skills.

All Children's Autism Training services are available in conformity with and to the extent authorized in the approved plan of care.

2. Respite

Respite care includes any services (e.g., traditional respite hours, recreation or leisure activities for the recipient and care giver; summer camp) designed to meet the safety and daily care needs of the recipient and the needs of the recipient's care giver in

relation to reducing stress generated by the provision of constant care to the individual receiving waiver services. These services are selected in collaboration with the parents and are provided by persons chosen and trained by the family. Persons providing respite services will be in compliance with all State and federal respite standards. Respite services are delivered in conformity with an individualized plan of care.

The amount and frequency of respite care (with the exception of emergencies) is included in each individual's plan of care.

FFP (Federal Financial Participation) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite is only available to primary caregivers in family settings. Respite is available when a primary caregiver is not compensated for providing some or all of the support or supervision needed by the client.

Respite services reimbursement may not exceed $4,000 annually.

3. Waiver-funded Children's Case Management

Waiver–funded children's case management (WCCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    1. Services are being furnished in accordance with the individual's care plan;
    2. Services in the care plan are adequate; and
    3. There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community: Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities. Billing for services is limited to a maximum of 60 days prior to the HCBS placement, and provider reimbursement follows waiver enrollment.

Level of care activities: Case management is responsible for assisting the Department, as requested, in scheduling meetings and providing information as

requested to Department staff responsible for completing initial and ongoing level of care activities.

Crisis Supports: Case management will provide assistance to the recipient and family, as necessary, in locating suitable alternative placement when the individual's health or safety is at risk.

Limitations:
Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Activities integral to the administration of foster care programs;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

The case manager will conduct a face to face visit with the parent at least monthly for the purpose of reviewing any need for change in the IFSP based on the changing needs of the child or the family.

Waiver-funded children's case management services are available to persons from one through seven years of age in this waiver.

4. Adaptive Equipment/Environmental Modifications

Environmental Modifications:
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

In addition to the above, environmental modifications services are measures that provide the recipient with accessibility and safety in the environment so as to maintain or improve the ability of the recipient to remain in community settings and employment. Environmental modifications may be made to a recipient's home or vehicle (wheelchair lift, wheelchair lock down devices, adapted driving controls, etc) for the purpose of increasing independent functioning and safety or to enable family members or other care givers to provide the care required by the recipient. An environmental modification provided to a recipient must:

(a) relate specifically to and be primarily for the recipient's disability;
(b) have utility primarily for a person who has a disability;
(c) not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
(d) not be in the form of room and board or general maintenance;
(e) meet the specifications, if applicable, for the modification set by the American national standards institute (ANSI).

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Adaptive Equipment:
Adaptive equipment necessary to increase independent functioning in completing activities of daily living when such equipment is not available through other sources may be provided. Adaptive equipment as needed to enable family members or other care givers to provide the care needed by the individual.

A comprehensive list is not possible because sometimes items are created (invented) to meet the unique adaptive needs of the individual, for example, an adult-sized "changing table" to enable a care giver to diaper and dress a person who has severe physical limitations; or specially designed switches that an individual with physical limitations can use to accomplish other tasks. Adaptive equipment will conform to the following criteria:

(a) relate specifically to and be primarily for the recipient's disability;
(b) have utility primarily for a person who has a disability;
(c) not be an item or modification that a family would normally be expected to provide

for a non-disabled family member;
(d) not be in the form of room and board or general maintenance;
(e) meet the specifications, if applicable, for the modification set by the American National Standards Institute (ANSI).

Adaptive equipment/environmental modifications reimbursement is limited to $4,000 annually in this waiver.

5. Occupational Therapy

These services will be provided through direct contact between therapist and waiver recipient as well as between the therapist and other people providing services to the individual.

Occupational therapists may provide evaluation, consultation, training and treatment.

Occupational therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

Occupational Therapy is capped at $4,000 annually in this waiver.

6. Physical Therapy

These services will be provided through direct contact between the therapist and the waiver recipient as well as between the therapist and other people providing services to the individual. Physical therapists may provide treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and activities of daily living; and
2. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Therapists will also provide consultation and training to staff or caregivers who work directly with waiver recipients.

Physical therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

Physical Therapy is capped at $4,000 annually in this waiver.

7. Speech Therapy

These services will be provided through direct contact between the therapist and the waiver recipient as well as between the therapist and other people providing services to the individual.

Speech therapy services may include:

1. Screening and evaluation of individuals with respect to speech and hearing functions;
2. Comprehensive speech and language evaluations when indicated by screening results;
3. Participation in the continuing interdisciplinary evaluation of individuals for purposes of beginning, monitoring and following up on individualized habilitation programs; and

Treatment services as an extension of the evaluation process, which include: Consultation with appropriate people involved with the individual for speech improvement and speech education activities to design specialized programs for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists will also provide training to staff and caregivers who work directly with waiver recipients.

Speech therapy services under the State Plan are limited. Maintenance therapy is not reimbursable, nor is participation in the interdisciplinary planning process.

This service is capped at $4,000 annually.

8. Transportation

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the plan of care. Whenever possible, family,

neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Legally responsible persons, relatives, legal guardians and other persons who are not employees of agencies with a DDP contract may be reimbursed for the provision of rides. In these cases, reimbursement will be less than or equal to the mileage rate set by the Department for a State employee operating a personal vehicle. The mileage rate is based on the operational expense of a motor vehicle and does not include reimbursement for work performed, or the driver's time. Reimbursement for rides provided by legally responsible persons or others must be related to the specific disability needs of a recipient, as outlined in the plan of care. Persons providing transportation must be licensed, insured and drive a registered vehicle, in accordance with the motor vehicle laws of the State of Montana.

For families who choose to self-direct respite: Persons providing respite services may be reimbursed by the FMS contractor for out of pocket transportation mileage costs when transporting a waiver service recipient with a personal vehicle in the delivery of respite in accordance with respite activities specified in the approved plan of care. In this case, the respite worker must meet the qualified transportation provider standards as verified by the FSM contractor to qualify for mileage reimbursement.

Under no circumstances will medically necessary transportation (transportation to medical services reimbursed under the State Plan) be reimbursed under the waiver if the service is reimbursable under State Plan transportation.

This service is capped at $4,000 annually. Transportation is considered an ancillary service. The sum of all ancillary service costs may not exceed $4,000 per year.

9. Individual Goods and Services

Individual Goods and Services are services, supports or goods that enhance opportunities to achieve outcomes related to living arrangements, relationships, inclusion in the community and work as clearly identified and documented in the service plan. Items or services under individual goods and services fall into the following categories:

*Membership/Fees: fitness memberships, tuition/classes, summer day programs, social membership (for example: outdoor clubs, friendship clubs, boy and girl scouts) and socialization supports (for example: fees associated with participating in Special

Olympics and community events such as the annual pancake breakfast, community picnics, fairs, art shows, cultural events and

*Devices/Supplies: batteries for hearing aids and batteries for assistive technology devices, nutritional supplements, diapers, instructional supplies, instructional books and computers.

Items covered under individual goods and services must meet the following requirements:

- The item or service is designed to meet the participant's functional, medical or social needs and advance the desired outcomes in his/her plan of care;
- The item or service is not prohibited by Federal or State statutes or regulations;
- One or more of the following additional criteria are met:

1. The item or service would increase the participants functioning related to the disability;
2. The item or service would increase the participants safety in the home environment; or
3. The item or service would decrease dependence on other Medicaid services;
   - The item or service is not available through another source; and
   - The service does not include experimental goods/services.

Recreational activities provided under Individual Goods and Services may be covered only to the degree that they are not diversional in nature and are included in a planning objective related to a specific therapeutic goal.

Montana assures that services, supports or goods provided under this definition are not covered under the Individuals with Disabilities Education Act (IDEA) or Section 110 of the Rehabilitation Act or available through any other public funding mechanism.

Individual goods and services must be approved by the planning team prior to purchase and reimbursement. In addition, goods and services purchased on behalf of the recipient by legal guardians, legally responsible persons, or other non-employees acting on behalf of the recipient are reimbursable only if receipts for such purchases are submitted to the agency with a DDP contract. The receipts are reimbursable only if all the requirements listed above have been met.

Goods and services projected to exceed $2,000 (annual aggregate) require prior approval by the DDP Regional Manager.

10. Program Design and Monitoring

The Program Design and Monitoring (PDM) staff person (a Family Support Specialist with an autism endorsement or a Board Certified Behavioral Analyst) develops formal written training plans and protocols using evidence-based training approaches based on applied behavior analysis to improve a child's functioning and performance. The training methods are based on practices with a strong scientific basis, as written in a formal training plan developed by the staff person providing Program Design and Monitoring. The formal training plan is written in accordance with the objectives specified in the child's plan of care (the IFSP). The following skill based interventions and treatments may be used by the staff person providing PDM services.

1. Applied Behavior Analysis (ABA)
2. Discrete Trial Training (DTT)
3. Pivotal Response Training (PRT)
4. Learning Experiences: An Alternative Program for Preschoolers and Parents (LEAP).

Specifically, this waiver service is designed to provide the formal training protocols and methods used by the children's autism trainer in helping the child acquire, retain, and generalize the self-help, socialization, cognitive, communication, organizational skills and the positive behaviors necessary to function successfully in home and community based settings. Training goals will be outcome based and progress toward goals will be evidenced by training data. Specifically, Program Design and Monitoring staff are responsible for the development and monitoring of training methods designed to improve a child's skills in the following areas, including, but not limited to:

1. Social skills, and related skills to enhance participation across all environments and relationships, including but not limited to imitation, initiation of social interactions with adults and peers, reciprocal exchanges and parallel and interactive play with peers and siblings;
2. A functional communication system which may include expressive verbal language, receptive language and nonverbal communication skills and augmentative communication;
3. Increased engagement and flexibility in the exhibition of developmentally appropriate behaviors, including, but not limited to, play behavior, attending

behavior, responding to environmental cues (including cues from the training staff and others) and cooperation with instructions;
4. Replacement of inappropriate behaviors with more conventional and functional behaviors;
5. Working with caregivers and others in the environment to implement accommodations and supports to promote the child's competence and positive behavior.
6. Fine and gross motor skills used for age appropriate functional activities, as needed;
7. Cognitive skills relating to play activity and academic skills;
8. Adaptive behavior and self-care skills to enable the child to be more independent.
9. Independent exhibition of organizational skills including, but not limited to initiating and completing a task independently, asking for help, giving instructions to peers and following instructions from peers, following routines, self-monitoring and sequencing behavior.

The training effort will occur in the customary and usual community locations where the child lives, plays, and socializes with peers. Training may be delivered in group settings with same age peers or in one to one settings, based on the assessed needs of the child. The majority of training will be delivered in one to one training.

The waiver-funded plan of care (formally, the Individualized Family Services Plan, or IFSP) is based upon the results of a formal assessment and identification of needs and provides the general goals and specific objectives toward which training efforts are directed. The plan of care also specifies the settings in which services will be provided. Staff providing Program Design and Monitoring are responsible for monitoring the implementation of formal and informal training, providing training specific to the formal training plan (as opposed to the plan of care, or IFSP) and the informal interaction techniques used by the children's autism trainer, family members and others who work with or interact with the child. Other responsibilities include serving as an active member of the planning team, modifying the formal written training plan and intervention protocols, as needed, and serving as a resource consultant to persons requesting technical assistance.

PDM staff may also provide general assistance and support to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, an individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance,

companionship or support to a person served on the waiver. Training includes instruction about the treatment regimes and other services included in the plan of care, use of equipment specified in the plan of care and includes those specific activities necessary to safely maintain the participant at home. Support must be aimed at assisting the unpaid caregiver in meeting the needs of the participant, All training for individuals who provide unpaid support to the participant must be included in the participant's plan of care.

For the purpose of this service "family members" are defined as persons who live with or provide care to a child served in the waiver, and may include a parent, step parent, legal guardian and grandparents.

The person providing PDM services will meet with the children's autism trainer (the CAT service provider) and the parents at least monthly, for the purpose of reviewing progress on the formal training objectives and reviewing the need for changes in the formal training plan.
Program Design and Monitoring (PDM) does not duplicate any other service available to the child, including those services under IDEA or the Montana Medicaid State Plan.

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